South Central Kansas Trauma Region
Associate Membership Application

Name _____

Credentials _____

Title/Position _____

Organization _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

E-mail _____

Describe your experience and/or interest in issues related to the quality of care for the trauma patient.

Please indicate which committee or sub-committee you have an interest in participating.

Staff Education

Injury Prevention

By-laws

Fax this form to Kendra Tinsley at 785-273-0737.